PROVINCE OF NOVA SCOTIA

REPORT OF THE

Provincial Tuberculosis Hospitals

NOVA SCOTIA SANATORIUM

AND

POINT EDWARD HOSPITAL

FOR THE YEAR ENDED DECEMBER 31

1970

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To His Honour,

THE HONOURABLE VICTOR deB. OLAND

Lieutenant-Governor of Nova Scotia

Sir:

I beg to present herewith the report of the Provincial Tuberculosis Hospitals.

I have the Honour to be

Sir,

Your most obedient servant,

Hon. D. Scott MacNutt
Minister of Public Health

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J.S. ROBERTSON, M.D., D.P.H.

Deputy Minister,

Department of Public Health

Sir:

I have the honour to submit the Twelth Annual Report of Provincial Tuberculosis Hospitals. This is made up of the Sixty-Sixth Annual Report of the Nova Scotia Sanatorium and the Twenty-Sixth Annual Report of the Point Edward Hospital. These reports cover the calendar year, 1970. They are preceded by Table A, a combined statistical report.

Respectfully submitted,

H.B. Colford, M.D., M.P.H.

Acting Administrator

Tuberculosis Control Services

TABLE A

COMBINED STATISTICAL REPORT

FROM THE NOVA SCOTIA SANATORIUM AND POINT EDWARD HOSPITALS

CONCERNING THE PATIENT POPULATION, EXCLUDING TREATMENT OF SICK STAFF

FOR THE CALENDAR YEAR 1970

	Nova Scotia Sanatorium Est. 1904	Point Edward Hospital Est. 1949	Total
Number of patients in hospital. January 1, 1970	128	37	165
Total admissions during year	450	143	593
Total under care during year	578	180	758
Total discharges during year	469	139	608
Total patients in hospital December 31, 1970	109	41	150
Total patient days	48,474	14,439	62,913
Total cost	$1,996,314.58	$788,757.91	$ 2,785,072.49
Cost per patient day	$37.56	$40.55	$38.20

Nova Scotia Sanatorium

Kentville, Nova Scotia

66th
ANNUAL REPORT

Calendar Year 1970

SIXTY-SIXTH ANNUAL REPORT

OF THE

NOVA SCOTIA SANATORIUM

FOR THE YEAR ENDING DECEMBER 31, 1970

GENERAL INFORMATION

Free treatment for tuberculous persons in Nova Scotia became effective July 1, 1946. Application for admission of a tuberculous or a suspected tuberculous patient to the Sanatorium is made by the family physician through the Director of the Health Unit of his district recommending further investigation and/or treatment of the patient. If approved, the Director then contacts the office of the Medical Director requesting the admission which is authorized without delay.

The Sanatorium may be reached daily by the Dominion Atlantic Railway. Taxis meet all trains at Kentville, from which it is only a short drive to the Sanatorium. There are good bus connections daily to and from Kentville.

An information pamphlet, "Health Ahead", is available from all Health Unit Directors and from the Sanatorium. Prospective patients should read this before coming forward for admission in order to be informed regarding clothing requirements, visiting hours for friends, and other pertinent matters.

NOVA SCOTIA SANATORIUM

Kentville, N. S.

1970

Honourable D. Scott McNutt
Minister of Public Health

-- ADMINISTRATIVE AND TECHNICAL STAFF --

MEDICAL - FULL TIME STAFF

Helen M. Holden, M.D., C.R.C.P.(C),F.C.C.P.	Medical Director
J. J. Quinlan, M.D., C.R.C.S.(C),F.C.C.P.	Thoracic Surgeon and Bronchoscopies
F. J. Misener, M.D., F.C.C.P.	Radiologist
A. Laretei, M.D.	Physician
Maria Rostocka, M.D.	Physician
*G. A. Kloss, M.D., F.C.C.P.	Physician
E. W. Crosson, M.D.	Physician

MEDICAL - CONSULTING STAFF

V. D. Schaffner, M.D., C.R.C.S.(C),F.A.C.S.	Surgeon
D. M. MacRae, M.D.,C.R.C.S.(C),F.C.C.P.	Bronchoscopist
B. F. Miller, M.D.,F.R.C.S.(Edin),F.R.C.S.(Can.)	Consultant in Orthopedics
P. P. George, M.D., M.S.(Psych.) C.R.C.P.(C)	Consultant in Psychiatry
C. E. Jebson, M.D., C.R.C.S.(C)	Consultant in Urology
*D. H. Kirkpatrick, M.D.	Consultant in Anaesthesia
A. M. Sutherland, D.D.S.	Consultant Dentist

ADMINISTRATIVE AND TECHNICAL

P. S. Mosher, B. Comm	Administrator
Miss E. Jean Dobson, R.N., B.Sc.N.	Director of Nursing
Mrs. K. Dakin, R.N.	Director of Nursing Service
Mrs. Catherine Boyle, R.N.	Director of Nursing Education
Miss Eileen Quinlan, B.Sc.	Director of Dietary Services
Miss Virginia Allen, B.Sc.	Asst. Director of Dietary Services
Miss Helen Morse, R.T.	Senior Laboratory Technician
D. M. Brown, B.A., B.Ed. M.S.W.	Social Worker and Director of Rehabilitation

* Certified in specialty of Provincial Medical Board

Mrs. Elaine Murray, B.Sc.R.T.	Senior X-ray Technician
Adi S. Jagosh, R.T.	Chief Technician, Physical Medicine Dept.
Hector McKean, R.R.L.	Chief Medical Records Librarian

CHAPLAINS:

Rev. Dale MacTavish, B.D., Co-ordinating Protestant Chaplain
Rev. G. E. Saulnier Roman Catholic Chaplain
Rev. J. Douglas Archibald, D.D., United Church Chaplain
Rev. W. A. Trueman Anglican Chaplain

Prof.(Rev.) Charles Taylor, B.A., B.D., (Acadia) S.T.M.(Andover Newton
Chaplain-Supervisor, Clinical Pastoral Training, Nova Scotia Sanatorium.
Associate Professor of Practical Theology, Acadia University

MEDICAL RECORDS COMMITTEE:
Dr. H. M. Holden, Chairman
Mr. A. H. McKean, Secretary
Dr. A. Laretei
Dr. M. Rostocka
Dr. G. A. Kloss
Miss E. J. Dobson, R.N.
Mr. P. S. Mosher

TISSUE COMMITTEE:
Dr. G. A. Kloss, Chairman
Dr. F. J. Misener, Vice Chairman
Dr. J. J. Quinlan

PHARMACY COMMITTEE:
Dr. M. Rostocka, Chairman
Mrs. Shirley Maxwell, C.D.C.,Secretary
Dr. H. M. Holden
Dr. E. W. Crosson
Miss E. J. Dobson
Mr. P. S. Mosher

HOSPITAL INFECTION COMMITTEE:
Dr. J. J. Quinlan, Chairman
Miss V. Skerry, R.N., Secretary
Dr. G. A. Kloss
Miss E. MacQuarrie, R.N.
Miss Helen Morse
Mrs. J. Ells
Charles Sheffield
Miss E. J. Dobson, R.N.
P. S. Mosher

FIRE PROTECTION COMMITTEE:
Mr. P. S. Mosher, Chairman
Dr. H. M. Holden
Miss E. Jean Dobson, R.N.
Mr. B. Robinson
Miss Eileen Quinlan
Mrs. J. Ells

The Nova Scotia Sanatorium was founded in 1904 and was the first provincially owned and operated sanatorium in Canada. During the early years of its existence when the "cure" consisted of bed rest, diet and fresh air, the institution grew rapidly and, by the end of the First World War, had reached a peak patient population of 400. During this period, many of the familiar brown wooden buildings in use today were built. The Sanatorium continued to operate at high levels of cccupancy until the 1930's when the first definitive treatment, surgery, was introduced. At the same time, the newest of the patient care facilities was constructed. 1947 saw the first use of a drug effective against tuberculosis and from then on the dramatic decrease in the incidence of the disease has been measured by closure of tuberculosis units and a substantial decline in the utilization of the Sanatorium.

The Annual Report for 1970 of the Administrator, Tuberculosis Control Services, indicates that the year had the lowest number of reported new cases of tuberculosis and reactivations (156) in the last ten years, and indeed, the lowest number since records have been kept. The impact on the operation of the Nova Scotia Sanatorium is obvious.

The total patient days treatment (Table I) was 48,474 in 1970, a decrease of 8 per cent from the previous year. Of this total, 41,072 were tuberculous patients, giving a reduction of 6,662 days care for the disease, or 14 per cent.

Discharges (Table II) were also down from the previous year. In 1970, there were 207 discharges of tuberculosis patients compared to 221 in 1969, or 6 per cent less.

The length of stay for first treatment patients has not changed significantly over the past three years and the average now stands at 331 days as shown in Table V. The trend from previous years of a high incidence of advanced disease on first admission continued. Of 50 first admissions, 44 (8%) were in this category. As would be expected, the average length of stay was progressive with the severity of the disease in each of the diagnostic groups. The range was 21 to 713 days.

The ages of tuberculous patients discharged showed a significant variation from the previous year. In 1969, 25 per cent were 60 years of age or older, and 50 per cent were 50 years of age or older. Of patients discharged in 1970, 38 per cent were over 60 years of age, and 63 per cent were over 50 years of age. The special significance of this trend is to lead us to question seriously the role of a Rehabilitation Department as it has existed in the past. Very few, if any, tuberculous patients require vocational retraining as a result of their disease, although some use their stay in hospital to upgrade their educational standing through the instructional staff of the Sanatorium or correspondence courses. The most obvious and pressing needs for rehabilitation services are in the area of social service, patient recreation, and education of school age patients.

The area served by the Sanatorium continues to be the whole province as noted in Table VI. The number of patients from the counties west of Halifax is disproportionately high in relation to admissions from the remaining ten counties. Fifty six per cent of discharges had residence in Western Nova Scotia. A recent survey indicated that 85 per cent of non-tuberculous admissions had residence in this area which would account for its high incidence of discharge. The report of the Administrator, Tuberculosis Control Services, tends to confirm this observation since only 23 of 130 new cases of tuberculosis were from the Fundy, Western and Lunenburg-Queens Health Units. The significance of this is the apparent value of the role that the Sanatorium is filling as a referral centre for nontuberculous chest diseases.

The nontuberculous program had a substantial increase over the previous year. Excluding sick staff, discharges of nontuberculous patients increased to 193 from 119 in 1969, or 62 per cent. Patient days care on this service, including sick staff, increased to 7402 (36%). This represents 15.3% of the total inpatient workload. The average length of stay of nontuberculous patients, excluding staff, was 37 days. The third floor of the East Infirmary building has been set aside for nontuberculous and surgical patients. The floor contains 29 beds plus two intensive care beds. The average daily census of nontuberculous patients on this floor was 19.5 and, because of the seasonal variation in demand, at many times during the year, it was filled to capacity with a

waiting list for admission. Table III (c) gives an analysis of the diagnosis of 158 patients discharged from this service during 1970.

The nontuberculous service has built up over a ten year period and it is our belief that we are barely scratching the surface of the potential volume. Since the service was established to make use of beds freed by the lower incidence of tuberculosis, it has not, in our opinion, grown as rapidly as it might have if formally recognized as a referral facility for public hospitals and covered by hospital insurance.

A total of 298 surgical procedures were performed during the year, 90 major and 208 minor. This compares to a total of 223 in the previous year and the increase is accounted for in minor procedures. Tables VIII A, B and C give an analysis of services.

The X-ray Department report (Table IX) shows a decrease of 2133 procedures and interpretations. This is 26% and is accounted for to a large extent by a decrease in outside films interpreted. The volume of outpatient x-ray examinations decreased by 5 per cent. While the total decrease may appear large in number, it was confined to low unit value examinations, making the actual decrease in workload substantially less than indicated by comparison of the total amounts for the two years. The film developing service for Health Units decreased by 8 per cent from the volume of 1969.

The volume of laboratory services (Table X) increased modestly by 4,154 units over 1969. With a decrease in work performed in the Nova Scotia Sanatorium laboratory of 429 units, the entire overall increase was in units referred out to other laboratories. However, laboratory personnel are involved in many and varied procedures for which work units are not assessed. These include blood gas analysis, pulmonary function testing, and specimen collection and dispatch for clinical investigation of new drugs, such as Rifampin. The willingness of the Patholoby Institute, Halifax, to deal promptly with our requests for service has enabled our laboratory to continue to give Milk and Water Analysis services to the Fundy Health Unit, and also cope with reasonable service demands of the Sanatorium in extremely cramped quarters.

The volume of visits to the Chest Clinic of the Outpatient Department decreased by 299 to 3020. The decrease is largely due to fewer staff being referred to the service since there was a slight increase in ex-patient referrals. One new case was diagnosed and one reactivated case was discovered. BCG vaccinations were given to 60 persons. The Clinic has continued to be responsible for the follow-up management of tuberculous veterans from mainland Nova Scotia, apart from those from the metropolitan Halifax area.

The Bronchoscopy service had an 18 per cent increase in volume during the year to 223 examinations (Table XI).

The Department of Physical Medicine is a composite service of physiotherapy, inhalation therapy, audiology, and electrocardiography. This appears to be an extremely practical arrangement as many of the procedures are inter-related and results in an economical operation in terms of staffing and greater co-ordination in service to both in-patients and out-patients.

The volume of physiotherapy treatments, 8650 (Table XI), was down 26 per cent from the previous year. However, this deficit is offset by an increase of 40 per cent to 11,091 in inhalation therapy treatments, giving a very slight overall increase.

A significant increase is shown in the volume of cardiorespiratory laboratory services (Table XI). Blood gas analysis workload has increased by 39 per cent and the pulmonary function testing has increased by 135 per cent. A substantial cause for the gain has been the greater utilization of the nontuberculous service.

Mental Health services, provided by the Fundy Mental Health Clinic, Dental services and other special examinations were carried out at volumes approximating those of the previous year.

The Nursing Department continues to discharge its functions of service and education with a high degree of dedication and skill. The department provided service to seven nursing units, the outpatient department, operating room and central supply. An active in-service education program

is being carried out on a continuing basis and, also, the department takes prime responsibility for the organization of the patient education program with the assistance of the Medical Staff and the Rehabilitation Department. Unfortunately, the Nursing Department experienced the highest staff turnover rate of all Sanatorium departments during the year, although this relatively high rate did not cause an extreme shortage of trained staff.

The educational role of the Nursing Department continued to be active throughout the year. Student nurses from six hospital schools of nursing were given a four-week course in tuberculosis nursing. To date, a total of 4071 student nurses have received instruction at the Sanatorium. It was confirmed during the year that this program would be terminated in early 1971.

The School for Nursing Assistants graduated 42 students in 1970, making a total of 462 who have completed the course since its inception in 1949. The upgrading of the course has required us to seek clinical training facilities closer to the Sanatorium in order to permit our instructors to follow the progress and instruction of the students much more closely than has been possible in the past. This made necessary the termination of our longstanding affiliation arrangement with the Payzant Memorial Hospital in Windsor which has given many of our graduates clinical experience in obstetrics, surgery and medicine. We express our sincere appreciation to that hospital for the substantial contribution that they have made to the

success of our program. Negotiations with the Blanchard Fraser Memorial Hospital in Kentville have been completed and early in 1971 our students will commence to receive part or all of their clinical experience in obstetrics, paediatrics, medicine and surgery at that hospital. Also, negotiations are underway with the Kings County Hospital in Waterville for a clinical affiliation in psychiatry beginning in 1972.

There is no doubt that the School for Nursing Assistants has made an important contribution by the provision of trained personnel to the hospitals of this area and the province as a whole.

The general service departments, Dietary, Laundry, Housekeeping, Maintenance and Plant operations provided the volume of service demanded by patient load and the nature of the physical plant. Staff turnover in these departments is very low, resulting in continuity of service and high morale. It was possible to close the diet kitchen in the West Infirmary building at the end of the year which will result in a cost reduction and, at the same time, improve service to the non-ambulatory patients in that building.

We would be remiss if we did not pay tribute to the members of the Sanatorium Fire Department who willingly volunteer their off duty time to attend training sessions and maintain a high standard of fire safety at the Sanatorium.

Calculation of the per diem cost of operation for the year ended March 31, 1970, has been included as part of this report. Expenses are reported in the Public Accounts and they will not be commented on here. The significance of the schedule is the per diem cost itself, which, for the period, is $37.56. This is a decrease of $2.14 from the previous year and was caused by a change in accounting which gives the institution credit for cost recoveries previously reported as a general revenue. However, the per diem cost will tend to fluctuate quite radically from year to year unless some means can be found to stabilize the volume of in-patients. The nontuberculous service is making a substantial contribution in this regard. Every effort is being made to reduce operating costs and to this end the nurses' residence was closed in September of this year and staff moved to the Dormitory building which was operating at less than fifty per cent occupancy.

We expressed our gratitude for faithful service to the following personnel who retired on superannuation during the year;

John A. Lawrence, Medical Records Clerk, 10 years service

Albert A. Longuephy, orderly, 17 years service

Lawrence P. Chase, orderly, 16 years service, because of ill health

Josetta Jardine, cook, 22 years service

Alice G. Newcombe, food supervisor, 11 years service

Hugh A. O'Handley, orderly, 43 years service

Cecelia Rose, nursing assistant, 10 years service

Charles St. C. Galley, painter, 20 years service

George A. Morton, Fireman's Helper, 13 years service

We were saddened by the accidental death of Lester B. Brewster in September. He was to have retired on October 31, 1970.

The relationship of the Sanatorium with the people of the town of Kentville and surrounding area continued on a high level. The Sanatorium is deeply indebted to the many individual citizens, service clubs, church, social, and fraternal groups that show their continued interest in the well being of the Sanatorium and our patients.

The past and future successes of the Sanatorium in its role in the control and eradication of tuberculosis and investigation and treatment of chest diseases is due in large measure to the valuable assistance received from the officials of the Department of Public Health, the Health Unit Directors, and the many government departments that provide services, both directly and indirectly,to the institution.

P. S. Mosher,
Administrator

STATISTICAL REPORT

FOR THE CALENDAR YEAR ENDING DECEMBER 31, 1970

Table I

	1970	1969	1968
Number of patients in residence at first of year	128	133	127
Number of patients admitted during the year	283	319	237
Number of patients readmitted during the year	167	163	124
Total number of patients treated during the year	578	615	488
Number of patients discharged during the year	469	487	355
Number of patients in residence at end of year	109	128	133
Number of patient days treatment	48,474	52,887	49,902
Number of patient days treatment - tuberculous	41,072	or 84.7 %	
nontuberculous	7,132	14.7	
staff	270	0.6	

Table II PATIENTS DISCHARGED CALENDAR YEAR 1970

TUBERCULOSIS:		
Active:		129
First treatment experience	92	
Re-treatment	23	
To continue treatment	14	
Inactive:		78
Investigation of activity	53	
Treatment of nontuberculous disease	25	
Total patients with tuberculosis		207
INVESTIGATION - PROVEN NONTUBERCULOUS:		193
New	158	
Previously treated at Sanatorium	35	
STAFF		69
TOTAL DISCHARGES		469

Table III(a)

PRINCIPAL DIAGNOSIS OF PATIENTS DISCHARGED AFTER TREATMENT FOR ACTIVE TUBERCULOSIS

Calendar Year 1970

	First Treatments	Transfers and Re-treatment
Primary infection active	15	
Reinfection pulmonary tuberculosis:		
Minimal	6	3
Moderately advanced	31	9
Far advanced	23	21
Pleural tuberculosis	1	
Meningitis	2	
Peritonitis	1	
Spondylitis	2	1
Tenosynovitis		1
Genitourinary tuberculosis	5	1
Adenitis	6	1
TOTAL	92	37

Table III (b)

PRINCIPAL DIAGNOSIS OF PATIENTS DISCHARGED WHO HAD INACTIVE TUBERCULOSIS ON ADMISSION

Mycobacteriosis	1
Sarcoidosis	1
Primary malignant neoplasm of lung	3
Secondary malignant neoplasm of lung	1
Pneumonia	5
Acute bronchitis	1
Asthma	1
Chronic obstructive lung disease	7
Abscess of lung	3
Abscess of wrist	1
Lymphadenitis	1
TOTAL	25

Table III (c)

DIAGNOSES OF NONTUBERCULOUS PATIENTS DISCHARGED

Calendar year 1970

(Staff and those previous treated for same disease excluded)

031	Mycobacteriosis	2
135	Sarcoidosis	8
161	Malignant neoplasm of larynx	1
162	Primary malignant neoplasm of lung and bronchus	15
197	Secondary malignant neoplasm of lung	7
320	Meningitis	1
446	Polyarteritis nodosa	2
485	Bronchopneumonia	8
486	Pneumonia, other	10
491	Chronic bronchitis	13
492	Emphysema	4
493	Asthma	8
499	Chronic obstructive pulmonary disease	16
507	Hay fever	1
510	Empyema	4
511	Pleurisy with effusion (nontuberculous)	3
512	Spontaneous pneumothorax	5
513	Abscess of lung	5
515	Pneumoconiosis	1
516.1	Farmers lung	3
518	Bronchiectasis	5
	Crushing injury to the chest (automobile accident)	5
	Gunshot wounds to chest	2
	Foreign body in bronchus	3
	Other sundry diagnoses	13
	No significant disease or no diagnosis	13
TOTAL		158

Table IV

AGE GROUP OF PATIENTS DISCHARGED
CALENDAR YEAR 1970

AGE GROUP	TUBERCULOUS			NONTUBERCULOUS		
	MALE	FEMALE	BOTH SEXES	MALE	FEMALE	BOTH SEXES
0 - 4	6	3	9	1		1
5 - 9	3		3			
10 - 14	1	2	3	1	2	3
15 - 19	2	3	5	3	4	7
20 - 29	7	8	15	14	6	20
30 - 39	9	7	16	10	5	15
40 - 49	20	18	38	21	11	32
50 - 59	31	12	43	33	13	46
60 - 69	22	12	34	33	10	43
70 - 79	21	11	32	18	7	25
80+	6	3	9	1		1
ALL AGES	128	79	207	135	58	193

Table V LENGTH OF IN-HOSPITAL TREATMENT PERIOD

First Treatment Experience - Discharged on Medical Advice

Calendar Year 1968

Diagnostic Group	Number of Cases	Total Days	Range	Average Days
Minimal	13	2528	89 - 359	194
Mod. advanced	18	6044	183 - 470	336
Far advanced	14	6414	231 - 817	458
ALL CASES	45	14,986	89 - 817	333

Calendar Year 1969

Diagnostic Group	Number of Cases	Total Days	Range	Average Days
Minimal	16	3434	62 - 459	215
Mod. advanced	17	4484	66 - 442	264
Far advanced	15	7132	325 - 935	475
Miliary	3	1089	270 - 493	363
ALL CASES	51	16,139	62 - 935	316

Calendar Year 1970

Diagnostic Group	Number of Cases	Total Days	Range	Average Days
Minimal	6	1406	21 - 397	234
Mod. advanced	25	6907	90 - 419	276
Far advanced	19	8272	234 - 713	435
ALL CASES	50	16,585	21 - 713	331

Table VI

COUNTY OF RESIDENCE OF PATIENTS DISCHARGED

CALENDAR YEAR 1970

COUNTY	
Annapolis County	26
Antigonish County	15
Cape Breton County	5
Colchester County	8
Cumberland County	19
Digby County	18
Guysborough County	11
Halifax City	35
Halifax County	45
Hants County	20
Inverness County	8
Kings County	103
Lunenburg County	31
Pictou County	29
Queens County	7
Richmond County	1
Shelburne County	5
Victoria County	2
Yarmouth County	12
NOVA SCOTIA	400

Table VII

RELIGION OF PATIENTS DISCHARGED
Calendar Year 1970

Anglican	69 or 17.2%
Baptist	107 or 26.7
Buddhist	1 or 0.2
Catholic, Roman	97 or 24.2
Christian Reformed	1 or 0.2
Greek Orthodox	2 or 0.5
Hindu	4 or 1.0
Jehovah Witness	5 or 1.2
Lutheran	6 or 1.5
Pentecostal	5 or 1.2
Presbyterian	24 or 6.0
Salvation Army	2 or 0.5
Seven Day Adventist	2 or 0.5
United Church of Canada	71 or 17.7
Not stated	4 or 1.0
TOTAL	400 or 100%

Table VIII SURGICAL PROCEDURES
Calendar Year 1970

A. Pulmonary Resection

Indication: (including biopsy for diagnostic purposes)

Abscess, lung	1
Carcinoma, bronchogenic	8
Emphysema	3
Farmers Lung	2
Mycobacteriosis	1
Pneumonia lipoid	1
Pneumonia, unresolved	2
Polyarteritis nodosum	2
Sarcoidosis	3
Tuberculosis	23

For Pulmonary Tuberculosis: Type of operation

Lobectomy and segmentectomy	1
Lobectomy	4
Multiple segmentectomy	5
Segmentectomy + wedge resection	1
Segmentectomy	8
Wedge resection	4
	23

Operative Mortality (within 60 days) 0.0%*

* Based on tuberculosis cases only.

Table VIII (cont'd.)

B. Sundry Surgical Procedures - Major

Appendectomy	1
Colectomy and ileectomy	1
Exploration of loin sinus	1
Nephroureterectomy	4
Prostatectomy, retropubic	1
Rib resection and decortication	1
Rib resection and drainage of empyema	2
Spinal fusion	1
Splenectomy and repair of liver laceration	1
Splenectomy and repair of stomach and diaphragm	1
Thoracoplasty	2
Thoracostomy and biopsy of hilar node	1
Thoracostomy and bronchotomy	1
Thoracostomy and closure of bronchopleural fistula	1
Thoracostomy and excision of bronchogenic cyst	1
Thoracostomy and pleural abradment	1
TOTAL	21

C. Sundry Surgical Procedures - Minor

Amputation of toe	1
Application of plaster cast	8
Aspiration of abdominal fluid	4
Aspiration, joint	3
Aspiration, pleural fluid	78
Aspiration, soft tissue	1
Biopsy, muscle	2
Biopsy, pleural tissue	8
Biopsy, scalene node	11
Biopsy, skin	11
Cauterization of warts	1
Dilatation of sinus	37
Excision of bursa	2
Excision of gland	1
Excision of lipoma	3
Excision of skin lesion	18
Exploration of sinus	1
Incision and drainage of abscess	1
Mastectomy (male)	1
Removal of foreign body from esophagus	1
Removal of plaster cast	3
Thoracotomy	5
Tracheostomy	4
Unguectomy	3
TOTAL	208

Table VIII (cont'd.)

D. Anaesthesia:

Pentothal sodium + Nitrous Oxide + Fluothane + Syncurine + Anectine	72
Novocaine 2%	178
Pontocaine 2%	298
Xylocaine jelly	5
Spinal	2
Pontocaine + Novocaine	1
Nitrous Oxide + Fluothane	1
Pontocaine + Novocaine + Ephedrine	1

Table IX X-RAY DEPARTMENT REPORT

Abdominal, Flat film		27
Barium enema		5
Bones & Joints		300
Breasts		2
Bronchograms		71
Bronchospirometry		1
Chest		4773
Cystogram		4
Dental		26
Fistula contrast media		3
Gall Bladder		5
Gastrointestinal		26
Kidney-Ureter-Bladder		22
Oesophagus		3
Outside films interpreted		1059
for Atlantic Health Unit	277	
Others	782	
Planigrams		87
Sinus and Mastoid		10
TOTAL		6424

3069 Outpatient x-ray examinations included in above tabl

Film developing service for Department of Public Health:

Cobequid Health Unit	3603
Fundy Health Unit	1673
Lunenburg-Queens Health Unit	803
Northumberland Health Unit	2284
All Units	8363

Table X LABORATORY REPORT

Units of work performed:	1970	1969	1968
General laboratory	98,400	97,798	94,953
Milk and Water Laboratory	11,587	12,618	13,527
Total Units performed in Nova Scotia Sanatorium Laboratory	109,987	110,416	108,480
Units of work performed for the Sanatorium by Public Health, Red Cross, and Biochemical Laboratories, Halifax	21,589	16,989	14,667
Units of work performed for the Sanatorium by:			
Pathology Laboratory, Halifax	1,152*	1,264	1,432
Blanchard Fraser Memorial Hospital, Kentville	166	71	80
Total Units of work for Sanatorium Specimens	132,894	128,740	124,659

* Surgical and autopsy specimens rated at 8 units of work for each 144 operative specimens plus 8 complete autopsies.

Bacteriology:	
Atypical mycobacteria for identification, N.S.San.	13
" " " , Halifax	13
" " " , Toronto	13
Atypical mycobacteria sub-culture	96
Bronchoscopic specimens for tubercle bacilli:	
Concentrated cultures	255
Catalase testing	35
Cerebrospinal fluid specimens for tubercle bacilli:	
Direct cultures	28
Direct smears	5
Gastric lavages for tubercle bacilli:	
Concentrated cultures	824
Concentrated smears	180
Miscellaneous specimens for tubercle bacilli:	
Concentrated cultures	442
Concentrated smears	149
Direct cultures	151
Direct smears	79
Niacin testing	144
Nitrate reduction for tubercle bacilli	43
Sputum specimens for tubercle bacilli:	
Concentrated cultures	5207
Concentrated smears	1415
Tubercle bacilli sensitivities - N. S. San.	96
" " " - Ottawa (first line)	53
" " " - Ottawa (second line)	19

Urines for tubercle bacilli:	
Concentrated cultures	834
Concentrated smears	383
Secondary Organisms:	
Blood cultures	9
Cerebrospinal fluid culture	2
Environmental swabs	94
Fungi cultures	23
General antibiotic sensitivities	308
Miscellaneous cultures	479
Sputum	765
Sterilities	231
Throat and nose	1469
Urine	244
Biochemistry:	
Bromsulphalein	115
Collections	2706
Creatinine, blood	31
Gastric analysis	1
Glucose	1411
Glucose tolerance	6
Ictotest, serum	34
Non-Protein Nitrogen	1
Thymol Turbidity	1
Total Protein, A/G Ratio	50
Urea Nitrogen	596
Urine Calcium	1
Van den Bergh	50
Cytology collections	628
Cerebrospinal Fluid:	
Cell count	6
Chlorides	5
Protein	6
Sugar	5
Feces:	
Occult blood	137
Ova and Parasites	13
Urobilin	7
Hematology:	
Collections	782
Differential counts	1789
Eosinophils, smears	71
Hematocrits	1510
Hemoglobin estimations	2161
L. E. Cells	18
Mono Test	11
Partial Thromboplastin Time	14
Platelet counts	74
Prothrombins	13
Red Blood Cell Counts	48
Sedimentation Rates	1510
White Blood Cell Count	2239

Milks and Waters:	
Coliforms, total milk	519
Chocolate dairy drink	72
Cream	70
Ice cream	19
Ice cream mix	32
Milks	326
Coliforms, water - M.P.N. method	1411
Coliforms, water - Membrane filter method	226
Phosphatase, total	468
Chocolate dairy drink	66
Cream	62
Ice cream	17
Ice cream mix	29
Milks	294
Plate counts, milk	67
restaurant	741
Pleural Fluid:	
Specific Gravity	1
Protein	2
Serology:	
Collections	261
Urines:	
Individual constituents	1296
Phenolsulfonphthalein excretion test	1
Routine urinalysis	2151
Trichomonas smears	38
Urobilinogen	15
Tests Performed in the Biochemistry Department, Pathology Institute:	
Amylase	9
Acid Phosphatase	3
Bicarbonate	167
Biochemical Profile	515
Cephalin Cholesterol Flocculation	1
Chlorides	167
Electrophoresis, protein differential	25
17 OH-corticoids	14
Fat globules - sputum	2
Other urinary hormones	1
Potassium	167
Protein bound iodine	15
Transaminase - SGPT	66
Urine for pregnancy	8
Serum Thyroxine	1
Lipid Profile	1
Sodium	167
Cerebrospinal Fluid:	
Mastic Curve	3

Tests Performed in the Public Health Laboratory, Halifax:

Bacteriology:	
Culture for identification	8
Fungi culture	36
General sensitivity	1
Gonococcus smears	106
Ova and Parasites, concentrated	1
Stools for enteric	9
Widal	1
Gonococcus cultures	2
Hematology:	
Bone marrow	3
Differentials	3
Immunoelectrophoresis	3
L. E. Cells	18
Total Iron and Iron binding capacity	5
Hemosiderin	3
Pathology:	
Papanicolaou smears	1246
Special Studies:	
Aspergillosis Survey, Halifax	311
Bentonite Titre, Ottawa	236
INH Inactivation Study, Ottawa	4
Rifampin Study, Ottawa	28
Sarcoidosis Study, Montreal	9
Serology:	
Latex Fixation	12
Paul Bunnell	1
V.D.R.L.	516
Wassermann, blood	67
Wassermann, C.S.F.	3
Treponema Pallidum Immobilization	2
FTA-ABS	30
V.D.R.L. quantitative	8

Tests Performed in the Red Cross Laboratory:

Blood Group, cross match, Rh, for surgery	426
Blood Group and Rh	80
Maternal Antibodies	1

Tests Performed in the Blanchard Fraser Memorial Hospital Laboratory:

Cross match for surgery	30
Group and Rh	4

Table XI SPECIAL SERVICES

			1970	1969
A.	Outpatient Department:			
	Total visits to chest clinic		3020	3319
	Ex-patients	834		
	Staff	933		
	Others	1253		
	Number of old cases reactivated		1	0
	Number of newly diagnosed cases		1	1
	BCG Clinic:			
	Total vaccinations		60	75
	Nurses - graduate	1		
	- student	0		
	- other	35		
	Other hospital personnel	18		
	Others	6		
B.	Bronchoscopy Service:			
	Bronchoscopic examinations		223	189
C.	Physical Medicine Service:			
	1. Physiotherapy:			
	Electric muscle stimulation		198	294
	Exercise - active and passive		4345	6122
	Massage		160	212
	Infra Red Light therapy		2346	2870
	Short Wave therapy		287	664
	Steam Packs		602	710
	Wax baths		614	571
	Ultra sonic muscle stimulation		98	169
	2. Inhalation therapy:			
	Intermittent Positive Pressure Breathing		9516	7085
	Postural Drainage*		1312	822
	Postural Drainage to obtain cytology specimen		263	153
D.	Miscellaneous Diagnostic Procedures:			
	Department of Physical Medicine:			
	Audiograms		142	132
	Electrocardiograms		335	381
	Cardiorespiratory Laboratory:			
	Blood gas analysis		334	240
	Bronchospirometry		1	3
	Pulmonary Function Tests		251	107

* Postural Drainage includes 1249 with IPPB to facilitate the procedure.

Table XI (cont'd.)

E. Mental Health Services:

	Patients	Visits
Service by psychiatrists:		
Brain Disorders	13	18
Mental Deficiency	3	3
Psychiatric Disorders	11	20
Psychotic Disorders	1	1
Psychophysiological Disorders	4	5
Psychoneurotic Disorders	8	10
Personality Disorders	4	6
Reactive Depression	14	16
Alcoholism	2	2
Adult Situational Reactions	3	3
Involutional Depression	2	3
No psychiatric diagnosis	4	5
Total	69	92

F. Dental Services:

Examinations	181
Prophylactic Treatments	55
Extractions	218
Fillings	143
Artificial dentures (professional services only)	23

G. Special Examinations:

Allergy tests	36
Autopsy Examinations	11
Autopsy Rate 35%	
Cystoscopy	9
Dressings	123
Electrocardiograms interpreted for Point Edward Hospital	53
Eye examination	124
Esophegoscopy	2
Injection of joint	8
Lumbar puncture	8
Pelvic examintions	71
Piercing of ears	18
Sigmoidoscopy	1
Sternal puncture	7
Syringing of ears	50

NOVA SCOTIA SANATORIUM
PER DIEM COST CALCULATION
For Year Ended March 31, 1970

Account No.		
608	Automobile Expense	$ 1,764.75
611	Subscriptions, Periodicals & Books	684.86
647	Freight, Duty & Expressage	798.03
648	Heat, Light, Power & Water	141,229.06
672	Insurance	441.00
699	Maintenance of Buildings	1,709.20
700	Equipment and Maintenance	34,248.08
703	Medical and Drug Supplies	61,853.59
705	Miscellaneous	5,119.45
721	Postage, Telephone & Telegraph	9,364.59
725	Printing, Stationery & Office Supplies	7,047.27
727	Provisions	140,456.28
740	Salaries	1,458,508.34
743	Special Services	5,939.02
746	Supplies (Household & General)	42,601.47
760	Travelling Expenses	3,539.44
780	X-ray Supplies	5,691.41
		$1,920,995.84
741	Student Affiliation	(12,251.85)
Less:		
	Meal Cost Recoveries	(62,148.67)
	Rehab Dept.: Sale of Materials	(4,644.41)
	X-ray Accounts	(1,920.30)
	Net Costs per Public Accounts	$1,840,030.61
Other Expenditures:		
	Public Works	28,702.09
	Finance & Economics:	
	Superannuation	64,017.79
	Canada Pension	21,449.39
	Group Assurance	2,311.62
	Consolidated Health Plan	4,803.08
	Other Administrative Costs Including Audit	5,000.00
	Total Costs	$1,966,314.58
	Patient Days	52,354
	Cost per Patient Day	37.56
	Cost per Patient Day - Prior Year	39.70
	Increase (Decrease)	(2.14)

TWENTY SECOND ANNUAL REPORT

OF

POINT EDWARD HOSPITAL

N.S. Department of Public Health

Sydney, Nova Scotia

For the Calendar Year

Ending December 31, 1970

HONOURABLE D. SCOTT MacNUTT
Minister of Public Health

Doctor J.S. Robertson
Deputy Minister

Doctor H.B. Colford
Acting Administrator of Tuberculosis Control Services

MEDICAL STAFF

Medical Superintendent	Dr. D.S. Robb
Asst. Medical Superintendent	Dr. T.K. Krzyski
Consultants	Dr. D.B. Archibald - Urology
	Dr. W. MacIsaac - Bronchoscopy
Courtesy Consultants	Dr. H.R. Corbett - Radiology
	Dr. E.C. McDonagh - Psychiatry
	Dr. R. Mathieson - Pathology
	Dr. H.M. Holden - Electrocardiography

NURSING STAFF

Director of Nursing	Miss Katherine MacKenzie
Asst. Director of Nursing	Mrs. Flora McDonald
Head of Teaching Department	Mrs. Winnifred Protheroe - to March 31/70
O.R. Supervisor	Miss Helen Chiasson
Evening Supervisor	Miss Margaret Bates - Retired March 31/70
	Mrs. Lenore Lawley
Night Supervisor	Mrs. Edna MacDougall
Head Nurses	Miss Theresa Bisson
	Mrs. Irene Pierrynowski

ADMINISTRATIVE AND TECHNICAL STAFF

Administrator & Medical Supt	Dr. D.S. Robb
Chief Clerk	Mrs. Josephine MacKinnon
Stores Supervisor	Mrs. Isobel MacPherson
Medical Records	Miss Vivian Fraser
Dietitian	Miss B. Joyce Lewis
Housekeeper	Mrs. Maude Sutton
Laboratory	Miss Margaret Lamond
X-ray	Mrs. Ada O'Callaghan
Maintenance	Mr. Hubert Lewis
Rehabilitation	Mrs. Winnifred Protheroe - to Oct 17/70
	Mrs. Elizabeth Reid - from October 18/70

POINT EDWARD HOSPITAL
ANNUAL REPORT -- 1970

THE GOAL: TO ERADICATE TUBERCULOSIS

The objectives of the Tuberculosis Control Service Division of the Department of Public Health must remain the eradication of tuberculosis within the Province. That goal is elusive, for a large part of the adult population have positive tuberculin skin tests, indicating that they harbour viable tubercle bacilli within their bodies, a latent focus of disease which may reactivate at any time during the lifetime of the host.

Great progress has been achieved. The death rate from tuberculosis has fallen to one-tenth the figure at the time Point Edward Hospital was opened, to less than one-twentieth the figure at the time tuberculosis treatment was made "free" to residents of Nova Scotia, to one seventieth the figure at the time the first Provincial Sanatorium for Tuberculosis was opened in Nova Scotia. Tuberculosis is not the dread disease it once was. With newer and more effective methods of treatment there has been a great decrease, not only in mortality but also in morbidity -- in most patients the disease responds promptly to medical treatment, symptoms disappear, and the patient is able to return to a normal life, usually to his previous employment, within months rather than years. The number of new active cases discovered each year is also declining, but unfortunately at a very much slower rate, and the greater proportion of the new active cases discovered each year are already in the moderately or far advanced stages when discovered, so that they are already infectious and have had ample opportunity to infect

other members of their family or other contacts and associates, and so to perpetuate the disease in the community.

THE FUNCTION & PURPOSE OF POINT EDWARD HOSPITAL

The function of Point Edward Hospital in this struggle against the enemy, the tubercle bacillus, remains:

(a) The provision of diagnostic services for patients with chest diseases, particularly in cases where tuberculosis is suspected.

(b) The active treatment of persons suffering from active tuberculosis, either pulmonary or involving other organs.

(c) The prevention of the spread of the disease to others, by isolating the patient during the early infectious stage, and by teaching him techniques to reduce the hazard of spreading infection to others.

(d) The long term follow-up of former patients, to prevent their disease from again becoming active, or to discover any reactivation in an early and easily treatable stage.

No program of tuberculosis control can be effective in a vacuum. Basically our field of responsibility remains the hospital and patients referred to us, but we must work in close liaison with the Department of Public Health field staff, the Health Unit Directors and the Public Health Nurses, and also with the family physician who cares for patients both before and after their brief stay in the chest hospital and who is in a position to maintain a close supervision of the family.

FACILITIES: The Hospital was built during World War II as a Navy Hospital, part of the Point Edward Naval Base, across the harbour from the City of Sydney. In the immediate post-was period it was operated briefly by DVA, and then taken over by the

Nova Scotia Department of Public Health, for use as a Tuberculosis and Chest Disease Hospital. The former Navy Base is now operated as an Industrial Park, and contains the Canadian Coast Guard College (operated by the Department of Transport) and the Point Edward Adult Vocational Training Center (operated by the Province). The hospital property is leased from DEVCO, the Cape Breton Development Corporation, and contains in addition to the hospital building a Nurses' Residence, a Domestic Staff Residence, another barracks building converted for medical staff apartments. Two of the four apartments in this building are rented to Canadian Coast Guard College Staff, as is a new apartment built during the year in one wing of the Nurses' Residence. The hospital property also contains one gate-house apartment (occupied by one of our maintenance staff), a maintenance shop, a garage, and an emergency power plant. Buildings are heated by steam purchased from DEVCO. Chlorinated drinking water is also supplied by DEVCO, and electricity is purchased from Eastern Light and Power. The buildings are all of temporary war-time construction, and obviously will not last for ever, but with a good maintenance program (operated jointly by the N.S. Department of Public Works and the Department of Public Health) have been kept in reasonably good shape.

ADMISSION STATISTICS & TRENDS

During the year 143 patients were admitted to Point Edward Hospital. This represents a drop of 33% in the past five years, or a 58% drop from our peak year of 338 admissions in 1958. Point Edward Hospital was first opened as a Provincial Tb Hospital on January 15, 1949, initially with 187 beds set up and with a very high occupancy rate. As the number of patients declined it was

possible to reduce the overcrowding to 152 beds, and in 1969 the figure for "beds set up" was further reduced to 77 beds. On this basis, during 1970 we had a 52% average occupancy, or an average daily census of 40. The availability of "extra" beds has made it possible to abolish the one-time long "waiting lists", so that most patients can be admitted on request. Unfortunately, we are hampered somewhat by the design of the hospital (war-time navy style, with too many large wards and not enough small rooms) so that even with empty beds available it is still necessary at times to procrastinate on the admission of a patient "for investigation" until we can find a single room.

Of our tuberculosis admissions 35% had Moderately Advanced and 15% Far Advanced disease. 59.4% of all admissions were over 50 years of age, 19.6% over 70, whereas only 10.5% were in the first two decades of life -- tuberculosis today is an old folk's disease! Note also a high rate among our native population -- 12.6% of admissions were of Micmac Indian extraction, indicating a considerably higher rate of disease than in our non-Indian population.

Further statistical analysis of admissions and discharges may be found in the tables appended to this report.

TREATMENT OF TUBERCULOSIS

Each passing year sees the chemotherapy of Tb becoming more effective, as newer Anti-Tb agents are discovered and as a greater understanding makes possible the more effective use of the older drugs. The "first-line drugs" remain, as in the past, STREPTOMYCIN (given intramuscularly daily initially, subsequently reduced to three or two times weekly), ISONIAZID and PAS (both given orally). Medication must be with a combination of at least

two, and preferably three, effective agents (effective against the particular strain of bacilli infecting this specific patient), given in proper dosage, without significant interruption, over a sufficiently long period of time (we usually recommend two years following the last positive sputum). Two newer drugs, RIFAMPIN (which is still "experimental" in Canada and so not generally available) and ETHAMBUTOL, are very good, while the older second-line agents, such as ETHIONAMIDE, PYRAZINAMIDE, CYCLOSERINE, THIACETAZONE, KANAMYCIN, and VIOMYCIN have all been used as required. Unfortunately, a wide range of effective agents is required, as agents of first choice become useless because of the development of bacillary resistance, of patient allergy, or toxicity to specific agents. But with such a wide therapeutic armamentarium success is now virtually assured -- we have now no "chronic bacillary cases". During the year three such cases were brought under control; one man who had had a positive sputum for twenty-five years in spite of very considerable drug therapy in various combinations was discharged sputum negative for twelve months and disease inactive, conversion having finally been achieved by Ethambutol, Thiacetazone and PAS; another who had had a positive sputum for fifteen years in spite of considerable chemotherapy finally converted to negative on a combination of Ethambutol, Ethionamide, Cycloserine and Thiacetazone, although he remains a "respiratory cripple"; and a third patient, who had had a positive sputum for fourteen years and had been abandoned as a hopeless case because of hypersensitivity to effective medication, finally converted to negative on a combination of Ethambutol, Pyrazinamide and Isoniazid. These three cases which were once considered "hopeless" finally responded to chemotherapy, even before the Rifampin-Ethambutol-Isoniazid combination became available. In the future we expect

no "therapeutic failures", but obviously the best results may be expected in cases diagnosed in the early stages of the disease.

There remain a few patients for whom surgical resection of areas of residual disease will be the treatment of choice, but during the year only one such was transferred to the Nova Scotia Sanatorium for surgery, less than one percent.

DIAGNOSTIC SERVICES: Some 32 cases were admitted for investigation and treatment of conditions which proved to be non-tuberculous, and some 45 cases with Tb were admitted "for review and assessment" only. But all cases admitted, even with a proven pre-admission diagnosis, warrant a full investigation, not only to determine the full extent and nature of their already diagnosed disease (for intelligent treatment must be based on adequate information), but to discover or exclude other, and sometimes more serious, conditions masking in the shadow of the original diagnosis.

CHEST CLINICS: In addition to such In-Patient diagnostic services, the hospital operates a Chest Out-Patient Clinic largely for the control and follow-up of ex-patients still on active treatment (especially where such treatment includes the "second-line anti-Tb drugs" which are still considered somewhat more hazardous and therefore requiring closer supervision than do the standard SM, INH and PAS regimens). Also attending our Out-Patient Chest Clinics are patients referred to us by DVA, follow-up patients who appreciate the more complete investigation and the immediate verbal x-ray report we can give them, and other patients with chest problems referred to us by family physicians. During the year 264 patients made 459 visits to our Out-Patient Chest Clinics, and 46 staff members made 192 visits to our Staff Clinic. In addition, all staff members receive chest x-rays

periodically.

We are fortunate to have Doctor D.B. Archibald visit us regularly for cystoscopic examinations and urological consultations, and Doctor W. MacIsaac for bronchoscopic examinations and E.E.N.T. consultations. For laboratory assistance we are indebted to Doctor R. Mathieson, pathologist at the Sydney City Hospital, for general bacteriology, histology, and the more complicated biochemical procedures. To the Provincial Public Health Laboratories at the Pathological Institute in Halifax we are grateful for their processing of our Tb sputum cultures, with sensitivity studies of both first-line and second-line anti-Tb drugs, and also sputum Cytology. Doctor H.R. Corbett, Radiologist at St. Rita Hospital, has been most helpful in discussing puzzling x-ray films and in accepting patients for G.I. Series and other examinations which we were not equipped to tackle, and other radiologists in the area have likewise been most cooperative when called upon for assistance. The staff of the N.S. Sanatorium also have been helpful when films were referred to them in consultation, and Doctor H.M. Holden has been very obliging in providing Electrocardiographic interpretation and consultation services.

AFFILIATE TRAINING OF STUDENT NURSES

For many years Point Edward Hospital has been accepting student nurses from the six Hospital Schools of Nursing in the area, for a course in Tuberculosis and Chest Diseases. Initially this was a two-month course. Some years ago it was reduced to four-weeks, and recently, with the reduction in the Nursing Training from three years to two years, the affiliate course has been squeezed out altogether. Thus in 1970 we received our final twelve students, from St. Joseph Hospital, in two classes, in January and

February, and as of March our Affiliate program was terminated. Perhaps this is inevitable, but it is unfortunate that nurses of the future should be denied this experience, particularly at a time when the responsibility for tuberculosis diagnosis and treatment is falling increasingly upon General Hospitals.

REHABILITATION SERVICE: With the ever shorter period of hospitalization for Tb., and with the better treatment and more complete recovery making it practical for patients to return to their former occupations rather than seeking "a light job", the emphasis of the Rehabilitation Service is shifting from training for a lighter job to training for a better job, and to social service and occupational therapy. Children in their school years continue their schooling in hospital, those in Grade School under Mrs Louise MacDermid, and those in high school under tutors as required. We were happy to see one of our patients, Mary Gillis, graduate from Grade XII during the year and make plans for vocational training. Older patients are encouraged to take "upgrading", and we work in close liaison with the Rehabilitation Service of the Department of Public Welfare, so that interested patients may after their discharge from hospital continue to take standard Vocational Training or Trades Training.

Handicrafts are not only a pastime, keeping minds occupied and hands busy, but for a few of our patients have become a minor industry. The volume and the quality of the leatherwork turned out by some of our patients has been astounding. Other patients have engaged in hooking rugs, sewing, knitting, weaving, plastic foam work, model construction (with toothpicks or tongue depressors), etc.

Mrs W. Protheroe, who had been in charge of our Nursing Affiliate Education Program and who in mid 1969 took on the additional duties of Rehabilitation Supervisor, became full-time Rehab Super on the first of April, after the closing of the Nursing Affiliate Program. However, she was anxious to return to Nursing Education, and in mid-October transferred to the N.S. Sanatorium to become a Nursing Instructor. Her position was filled by Mrs Elizabeth Reid, whose former position as Head Nurse had become redundant with a reduction in the number of active nursing stations. In Rehabilitation she has taken hold and is doing an excellent job.

FIRE AT THE CAPE BRETON HOSPITAL

On the evening of May 8th one floor of the Cape Breton Hospital at nearby Sydney River was gutted by fire, and we immediately phoned to offer what assistance we could. Because of the decline in our patient population in recent years we had two empty wards, Ward D downstairs with a rated capacity for 44 beds, and Ward B upstairs with a rating of 28 beds. Actually both wards had been stripped for other activities, and there was some mad scurrying as we dragged mattresses, blankets and bedding out to set up for an influx of ninety-nine patients from the mental hospital. Beds were discarded, mattresses were lined up on the floors, and soon all were snug. Words of appreciation should go to our own staff members who pitched in to help set up on that first mad night, and also to the dietary staff who coped with a sudden trippling of their work load. But the main chore of supervising and caring for the patients was assumed by the Cape Breton Hospital Nursing staff, and I cannot express adequately my admiration for the patience, sympathy, and understanding shown by these nurses for the wrecks of humanity under their

care.

Four days later the patients were back in the Cape Breton Hospital, and we were left with our memories. It was a useful exercise from an Emergency Measures Planning viewpoint, although naturally the actual requirements of the situation had varied considerably from our existing "Disaster Plan".

HOSPITAL STAFF: At a time of a gradually decreasing patient population a similar staff reduction is desirable, although a fully proportionate reduction is extremely difficult to achieve. When the present Medical Superintendent was appointed to Point Edward Hospital the total payroll was for 199 persons. In 9½ years, this was reduced to 115 at the end of 1970, and there have been further reduction since then. Most of this reduction has taken place by "normal attrition", by not replacing persons who resigned or retired unless such replacement were absolutely necessary. As a result of this policy our present staff contains a high proportion who have been with us for ten, fifteen, or more years, who are loyal and devoted.

Medical Staff: As noted last year, our medical staff has been pared to the bone, with only two full time physicians, one of which is Medical Superintendent and Hospital Administrator. However, we have been fortunate in having a good consultative staff, Doctor D.B. Archibald in Urology and Doctor W. MacIsaac in Bronchoscopy, both of whom visit the hospital on a regular basis, and since the onset of MSI we have felt free to call in any physician or internist from the Sydney area as required. Doctor R. Mathieson in pathology and Doctor H.R. Corbett in Radiology have both been most cooperative, and we have also called

freely on the staff of the Pathological Institute in Halifax and the N.S. Sanatorium in Kentville for mail or telephone consultation as required.

Nursing Staff: Insofar as the usual patient is concerned, it is the Nursing staff which sets the tone of the hospital, and we are happy to state that the level of nursing care offered to our patients is very high indeed. We have been fortunate in having a most capable and devoted nursing staff, under the direction of Miss K. MacKenzie. Highlight (or perhaps the low point) of the year was the retirement of Miss Margaret Bates, for many years Evening Supervisor in this hospital, and before that on the staff of the St. Joseph Hospital Tb. Annex in Glace Bay. We wish her many healthy and happy years ahead. Also retired, because of health, were Mrs Margaret Shaw, Mrs. Hattie Goodwin, and Mr Daniel ("Dougie") MacNeil. One CNA was transferred to the V.G. Hospital and one resigned, while one new CNA was appointed during the year.

Administrative and Technical: There have been no changes during the year in the Administrative, business and technical staff, and all divisions have operated smoothly and efficiently.

Dietary & Housekeeping: The dietary and housekeeping staffs have been unique in that while senior staff members and some at the domestic staff level have been Civil Servants, others at the Domestic staff level are Unionized employees, under the C.B.R.T. & G.W. This dichotomy has created some administrative difficulties and some inequities, but with mutual goodwill and understanding the minor problems are being ironed out. Staff numbers are gradually being reduced by attrition, but are still too high. Individuals at all levels do their tasks with a will,

so that even with an old building and old equipment standards remain high.

Maintenance Staff: There have been no changes during the year in the maintenance staff. Day to day maintenance remains the responsibility of our staff of nine. The Department of Public Works provide paint and other maintenance supplies, and lets out on tender major projects beyond the scope of our limited maintenance staff.

STAFF TRAINING: It remains Departmental policy to encourage staff members to attend medical conventions and institutes. During the year the In-Service Training Program was continued within the hospital, and Head Nurses and Supervisors were encouraged to attend the weekly medical staff meetings.

In May Miss K. MacKenzie, Director of Nurses, attended the annual meeting of the Registered Nurses Association of N.S. in Kentville, and shortly afterwards Doctor Robb, Medical Superintendent, and Mrs Flora McDonald, Assistant Director of Nursing, were privileged to attend the annual meeting of the Canadian Tuberculosis and Respiratory Disease Association in Winnipeg (and to follow the departmental policy of paying a portion of their own travelling expenses).

In the fall Doctor Robb and Mrs Elizabeth Reid attended the annual meeting of the Nova Scotia Division of the Canadian Public Health Association in Kentville, Mrs Reid also using the occasion to pick up a few tips from the Rehabilitation Service at the N.S. Sanatorium to help her in her new position as Rehabilitation Supervisor at Point Edward.

In November five members of the Nursing Staff attended an Institute on Disaster Nursing, held at St. Rita Hospital in Sydney, and the following month five nurses attended the Management Workshop for

Head Nurses, also held in Sydney.

Mrs Christine Stewart, Assistant Housekeeper, attended a course in Supervision sponsored by the Civil Service Commission, in Halifax.

Those attending conventions and institutes were expected to report back to their confreres, to the monthly "In-Service Training" meeting or to the weekly meeting of Head Nurses and Supervisors. Other programs included films on medical subjects, housekeeping problems, fire prevention, and so forth, with film strips, discussions, lectures, etc. The series was useful, and is being continued.

COMMUNITY SUPPORT: Throughout the year many individuals and groups continued to support the hospital, the patients and staff, in many varied ways, and to all of these is due a word of thanks, to family and friends, to clergymen of the various faiths who visited so faithfully, to such groups as the Suburban West Side Kinsmen Club who sponsored monthly card parties, to the St. Mary's and St. Timothy's Anglican Church Women of Glace Bay, who sponsored Bingo and Card parties, to the Ashby Command of the Royal Canadian Legion who donated a T.V. set for patient use, to the Branch 12 of the Canadian Legion, the Girl Guides, the Beinn Breigh Chapter and the Louisbourg Chapter of the IODE, to the Order of the Eastern Star, to the United Church Women of Westmount and of Beechmount, to the St. Theresa Catholic Women's League, the Ladies Auxiliary of St. Rita Hospital, the staff of Snow White Laundry -- to many groups and individuals who at Christmas time or throughout the year gave books or magazines for the patients' library or supplied treats to the patients.

Also to be remembered are the Salvation Army band, the

choirs of the Westmount United Church and the Calvary Baptist Church, and the individual entertainers who sang or supplied music or otherwise contributed to the happiness of the patients. To all, our thanks.

AND WHAT OF THE FUTURE?

It is obvious that there has been a gradual decline in the number of Tbc patients admitted to hospital, and in their length of stay, and it is likewise obvious that this is a continent-wide and even a world-wide phenomenon, a trend which is likely to continue. Declining utilization of hospital beds result in higher per-diem costs, and this increasing cost must of necessity put pressure on government to terminate an increasingly costly service and so spend the money elsewhere. Even if this were not so, the fact that the buildings were originally "temporary" and will not last for ever, should require that plans be made for the future. With definite plans made, and a schedule and dates set, it should be possible to make intelligent plans for the patients, for the staff, and for the buildings and equipment. There are a number of points which might be made:

(a) There are those who would argue that in times of high unemployment one major function of a government-operated hospital should be to provide employment. This is indeed a worthy goal, but our chief function must be to provide a service, a service that is necessary to the people of Cape Breton Island and the Province of Nova Scotia, and to supply that service at a cost which is competitive. Thus the more effective we are in holding costs down, the longer we will be "in business".

(b) Point Edward Hospital is at present offering a service to the Cape Breton area, to patients under treatment for Tb and to their families

and contacts, to patients requiring follow-up of previously diagnosed disease, and to patients with non-tuberculous chest conditions. It is not reasonable to discontinue such services without making plans for adequate replacement.

(c) A reasonable alternative service should include a good chest unit in one of the general hospitals in the area, preferably in Sydney. It should have perhaps thirty beds for the admission, investigation, isolation and treatment of cases of pulmonary disease, including those of active infectious pulmonary tuberculosis. No hospital in the area has at present the beds and facilities to meet such requirements.

(d) With the present wide range of effective anti-Tb drugs, and an even more effective combination of Rifampin, Isoniazid and Ethambutol available in the near future, the initial "cure rate" for new active cases should approximate 100%, with the chief problem being that of assuring that the patient continue recommended therapy faithfully for a couple of years post-discharge.

(e) It is in this matter of home therapy that most present regimens of treatment fall down, and consequently facilities for adequate supervision of home therapy are vitally important.

(f) Of similar importance is the matter of long-term follow-up of old cases. Tb has been known as a relapsing disease, with reactivation possible even after many years, and consequently an effective program of life long periodic chest x-rays and sputum cultures is important. Whether this should be conducted by the Department of Public Health Unit Director or by the newly organized "Chest Unit" is a matter for negotiation.

(g) Bringing Tuberculosis back into the mainstream of medicine by bringing the Chest Unit back to the General Hospital should have advantages for both services, making easier consultations, and providing for a cross-fertilization of medical knowledge and information. The Sanatorium-trained physician is a dying breed. His place is being taken by the Internist trained in Chest medicine and respiratory physiology. The Internist and the General Practitioner must learn the vagaries of the tubercle bacilli if this white plague of years past is to become a disease of the past.

(h) It has frequently been pointed out that there is a need in the community for "long-term treatment beds", for "convalexcent care beds", and the like, and some have suggested that if Point Edward Hospital were to be closed as a Tuberculosis and Chest Disease Hospital, the building should be converted for some such long term purpose. Unfortunately, the building is not suitable for such a purpose. Firstly, it does not have a sufficient number of small rooms, and has too many large wards. These could perhaps be converted, at an appreciable capital cost, but even if this were done the building would remain a "fire-trap". This hazard has been acceptable with 90% of our patients fully ambulant and quite capable of getting out of a burning building with minimal supervision; the staff could evacuate a limited number of disablod patients. But in a "chronic long-stay hospital" a large percentage of patients would require major assistance in evacuation, and a limited staff could not cope with a 3:00 a.m. fire. For such patients a modern fire-proof building should be essential.

Whatever changes the future may bring, an intensive anti-tuberculosis program must be maintained, stressing the early

discovery of new active cases, adequate chemotherapy initiated in hospital but continued on a long-term properly supervised home therapy regimen (with uncooperative patients or those whose disease presents complications being readmitted to hospital for surgery or other necessary treatment), and stressing also a diligent searching out of contacts and life-long surveillance of all cases of once-active disease. With such a program Tuberculosis can be controlled, and we trust some day eradicated.

D.S. Robb, M.D.
Medical Superintendent

PER DIEM COSTS -- POINT EDWARD HOSPITAL
Fiscal Year - April 1, 1969 to March 31, 1970

608	Automobile & truck expense	$ 697.77
611	Subscriptions, periodicals and books	98.45
648	Heat, Light, Power and Water	60,747.52
672	Insurance	56.00
690	Laboratory Expenses	312.61
691	Laundry Expenses	13,952.16
700	Equipment and Maintenance	5,459.90
703	Medical and Drug Supplies	4,994.48
705	Miscellaneous	2,125.06
721	Postage, Telephone and Telegraph	4,124.37
725	Printing, Stationary and Office Supplies	1,364.10
727	Provisions	68,222.17
740	Salaries	586,241.91
746	Supplies, Household and General	14,508.53
760	Travelling Expenses	1,490.49
780	X-Ray Supplies	1,582.79
782	Wages	6,657.60
701	Rehabilitation Supplies	1,092.10
		$ 773,728.01
	Less:	
741	Student Affiliation	4,761.35
	Meal Cost Recoveries	20,350.87
	Apartment Rentals	1,800.00
	Net Costs per Public Accounts	$ 746,815.79
	Other Expenditures:	
	Department of Public Works	$ 7,497.89
	Department of Finance & Economics:	
	Superannuation	21,454.80
	Canada Pension	8,496.41
	Group Assurance	685.77
	Consolidated Health Plan	1,807.25
	Other Administrative Costs, including Audit	2,000.00
	Total Costs	$ 788,757.91
	Patient Days	19,452
	Cost per Patient Day	40.55
	Cost per Patient Day for fiscal year 1968-69	35.15

Comment: Because of differences in accounting methods between the Province-operated hospitals and those operated under the N.S. Hospital Insurance Commission, a direct comparison of statements is difficult. The above figures include the costs of medical care to patients (except for the few consultants who submit bills directly to H.S.I. on a fee-for-service basis) whereas most per-diem cost figures exclude the cost of professional services. Costs above are not distributed to individual departments. The figure for Laboratory Expense includes a large retroactive credit from the previous fiscal year.
Nevertheless, it is recognized that costs are increasing at an alarming pace and every effort is being made to keep these in line.

POINT EDWARD HOSPITAL

ANNUAL REPORT

For the Calendar Year ending December 31, 1970

TABLE 1 -- STATISTICAL REPORT OF ADMISSIONS AND DISCHARGES:

	Male	Female	Total
Patients in hospital at beginning of year	28	9	37
Total Admissions during the year	97	46	143
Total Under Care during the year	125	55	180
Total Discharges during the year	101	38	139
Patients in hospital at end of the year	24	17	41
Total Patient-days	9322	5117	14439
Average Daily Census	26	14	40
Patient-days of patients discharged or dead			22838
Average length of Hospital Stay			164

STATISTICAL REPORT -- COMPARISON WITH 5 RECENT YEARS

	1965	1966	1967	1968	1969
Patients in hospital at beginning of year	88	74	70	52	64
Total Admissions during the year	217	188	173	193	165
Total Under care during the year	305	262	243	245	229
Total Discharges during the year	231	192	191	181	192
Patients in hospital at end of the year	74	70	52	64	37
Total Patient-days	31435	29146	25129	21715	22263
Average Daily Census	86	80	69	59	61
Patient-days of patients discharged or dead	36221	35393	25217	20391	26391
Average length of Hospital Stay	158	184	131	112	138

TABLE 2 -- ADMISSIONS DURING THE YEAR - SOURCE OF PATIENTS

TUBERCULOUS	Male	Female	Total
First Admissions	29	18	47
Readmissions, to resume treatment	8	5	13
Readmissions, to continue treatment	2	2	4
Transfers from other Tb Hospitals	2	-	2
For review and Assessment only	32	13	45
Total	73	38	111
NON-TUBERCULOUS			
Staff	-	-	-
Other, for investigation & treatment	24	8	32
Total	24	8	32
Total Admissions	97	46	143

TABLE 3 -- ADMISSIONS: DIAGNOSIS OF PATIENTS ADMITTED

TUBERCULOUS	Male	Female	Total	Percent
Primary	3	2	5	4.6
Minimal	17	8	25	22.5
Moderately advanced	23	16	39	35.1
Far advanced	11	6	17	15.3
Miliary	2	2	4	3.6
Anthraco-silico-tuberculosis	13	-	13	11.7
Meningitis, tbc.	1	1	2	1.8
Adenitis, inguinal, tbc	-	1	1	.9
Genito-urinary tuberculosis	3	2	5	4.5
	73	38	111	100.0

NON-TUBERCULOUS	Male	Female	Total
Staff:	-	-	-
Other, for investigation and treatment			
Bronchitis	3	-	3
Chronic bronchitis with chronic obstructive pulmonary emphysema	3	-	3
Bronchiectasis	1	-	1
Bronchopulmonary cysts with secondary infection	-	1	1
Bullous emphysema with recurrent spontaneous Pneumothorax	-	1	1
Diffuse Cystitis	1	-	1
Pulmonary infarct	-	1	1
Pneumonia	6	3	9
Pneumoconiosis	1	-	1
Duodenal ulcer with haematemesis	1	-	1
Sarcoidosis	-	1	1
No disease demonstrated	2	-	2
Chronic lung abscess	1	-	1
Pulmonary Fibrosis	3	-	3
Fibrothorax	1	-	1
Suspected polycythemia rubra vera	1	-	1
Osteochondritis juvenilis lumborum	-	1	1
	24	8	32

Tuberculous	73	38	111
Non-tuberculous - staff	-	-	-
- other	24	8	32
TOTAL ADMISSIONS	97	46	143

TABLE 4 -- ADMISSIONS: AGE and SEX of PATIENTS ADMITTED

	TUBERCULOUS			NON-TUBERCULOUS			TOTAL		
Age	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-9	1	2	3	-	-	-	1	2	3
10-19	5	4	9	2	1	3	7	5	12
20-29	7	8	15	2	1	3	9	9	18
30-39	7	3	10	2	-	2	9	3	12
40-49	3	5	8	4	1	5	7	6	13
50-59	23	6	29	5	2	7	28	8	36
60-69	12	3	15	5	1	6	17	4	21
70-over	15	7	22	4	2	6	19	9	28
Total	73	38	111	24	8	32	97	46	143

TABLE 5 -- RESIDENCE OF PATIENTS ADMITTED:

Cape Breton County	102	
Inverness County	18	
Victoria County	14	
Richmond County	6	
CAPE BRETON ISLAND		140
Antigonish County	3	
NOVA SCOTIA MAINLAND		3
TOTAL ADMISSIONS		143

TABLE 6 -- SPONSORSHIP OF HOSPITALIZED PATIENTS

	In Hosp Jan 1/70	Admitted 1970	Discharged 1970	In Hosp Dec 31/70	Hosp Days
Dept National Health & Welfare					
(a) Immigration Medical Service	-	-	-	-	-
(b) Indian and Northern					
-- Eskasoni Agency	7	18	24	1	1811
-- Shubenacadie Agency	-	-	-	-	-
(c) Sick Mariners' Service	-	-	-	-	-
Dept of Veterans' Affairs	-	2	2	-	41
Total Federal Responsibility	7	20	26	1	1852
Province of Nova Scotia "	30	123	113	40	20986
Other Provinces - Reciprocity	-	-	-	-	-
TOTAL	37	143	139	41	22838

TABLE 7 -- DISCHARGES DURING THE YEAR: CLASS OF PATIENT

	Male	Female	Total
Tuberculous	76	30	106
Non-Tuberculous			
Staff	-	-	-
Other	25	8	33
Total	101	38	139

TABLE 8 -- DISCHARGES: ADMISSION DIAGNOSIS OF DISCHARGED TBC PATIENTS

	Male	Female	Total	Percent
Primary	2	2	4	3.8
Minimal	15	4	19	17.9
Moderately Advanced	26	14	40	37.7
Far Advanced	10	5	15	14.2
Miliary	3	1	4	3.8
Genito-urinary Tb.	4	2	6	5.7
Anthraco-silico-tuberculosis	16	-	16	15.1
Tbc. Adenitis	-	1	1	.9
Tbc. Endometritis	-	1	1	.9
Total	76	30	106	100.0

TABLE 9 -- DISCHARGES: CLINICAL CONDITION OF PATIENTS ON DISCHARGE

	Male	Female	Total	Percent
Pulmonary Tuberculosis:				
Inactive	39	13	52	49
Quiescent	23	10	33	31
Active - improved	5	2	7	6.6
Active - unimproved	1	1	2	2
Dead - from Tb. or complication	-	-	-	-
Dead - from unrelated disease	4	-	4	3.8
Extra-pulmonary Tuberculosis:				
Inactive	1	1	2	1.9
Quiescent	3	3	6	5.7
Active - improved	-	-	-	-
Active - unimproved	-	-	-	-
Dead	-	-	-	-
Total	76	30	106	100.0
Non-Tuberculous:				
Recovered or Improved	13	7	20	60.6
Unimproved (investigation only)	11	1	12	36.4
Dead	1	-	1	3
Total	25	8	33	100.0

TABLE 10 -- DISCHARGES: TYPE OF DISCHARGE OF TBC PATIENTS

	Male	Female	Total	Percent
On Medical Advice	64	28	92	86.8
Transfer to N.S. Sanatorium	-	1	1	.9
Transfer to other Tb Hospitals	1	-	1	.9
Irregular Discharges				
Against advice	7	1	8	7.5
Disciplinary	-	-	-	-
Died	4	-	4	3.8
Total	76	30	106	100.0

TABLE 11 -- MARITAL STATUS - ALL DISCHARGED PATIENTS

Single	35	10	45	32.4
Married	58	16	74	53.2
Widowed	7	10	17	12.2
Separated	1	2	3	2.2
Divorced	-	-	-	-
Total	101	38	139	100.0

TABLE 12 -- RELIGION - ALL DISCHARGED PATIENTS

Roman Catholic	66	31	97	69.8
United Church of Canada	12	2	14	10.1
Salvation Army	1	1	2	1.4
Church of England	10	3	13	9.4
Presbyterian	9	1	10	7.2
Baptist	1	-	1	.7
Pentecostal	1	-	1	.7
Protestant (Non-denominational)	1	-	1	.7
Total	101	38	139	100.0

TABLE 13 -- PATIENTS DISCHARGED - TUBERCULOSTATIC DRUGS USED WHILE IN HOSP.

Streptomycin	54
Isoniazid	69
PAS	52
Cycloserine	19
Ethionamide	5
Ethambutol	4
Pyrazinamide	6
Thiacetazone	1
Isoxyl	1
Viomycin	1

TABLE 14 -- TBC PATIENTS DISCHARGED - ASSOCIATED TBC COMPLICATIONS
(for principal Tb Diagnosis refer to Table 8)

Bronchiectasis	16
Cervical Adenitis	1
Endobronchitis	1
Laryngitis	1
Pleurisy with effusion	3
Enterocolitis	1
Renal Tb	4
Tbc Hip	1
Tbc Hip with pathological fracture	1
Tbc Sinus of hip (post-op)	1
Tbc Spondylitis	1
Tbc Cystitis	1
Pleuritis, inactive (Fibrothorax)	1
Pulmonary Tb., minimal inactive	1
Ureteral Stricture	1

TABLE 15 -- TBC PATIENTS DISCHARGED - ASSOCIATED NON-TBC COMPLICATIONS
(for principal Tb Diagnosis refer to Table 8)

Respiratory System:	
Bronchopneumonia	13
Chronic Bronchitis	4
Chronic Bronchitis with emphysema	3
Emphysema, obstructive	2
Emphysema, compensatory	5
Pulmonary oedema	1
Pulmonary fibrosis	3
Fibrothorax	1
Pleurisy	1
Influenza	2
Sarcoid reaction	1
Emphysematous cyst	2
Spontaneous Px	1
Bronchiectasis	1
Diseases of the skin:	
Erythema Nodosum	1
E.E.N.T.:	
Chronic Laryngitis	1
Chronic otitis media with deafness	2
Chronic Rhinitis	1
Atrophic Rhinitis	1
Nasal Septal Deviation	1
Exotropia	1
Nervous System:	
Alcoholism	6
Schizophrenia	4
Ex-Schizophrenic State	1
Epilepsy	4
Mental Retardation	3
Peripheral Neuritis	1
Hypochondriasis	2
Hyperkinesia	1
Senile Dementia	1
Peripheral Neuropathy	1
Chronic Brain Syndrome	1
Depression, drug induced	1
Depressive psychosis	1
Anxiety state	2
Bones and Joints:	
Osteoarthritis	3
Congenital Cleidocranial Dyostosis	1
Systemic:	
Lues, latent	2
Phenylketonuria	1
Hypersensitivity to SM	2
Hypersensitivity to PAS	2
Hepatotoxicity	1
Hypersensitivity to Pontocaine	1
Digitalis Toxicity	1

CONTINUED ON NEXT PAGE .....

TABLE 15 Continued -- ASSOCIATED NON-TBC COMPLICATIONS IN DISCHARGED TB PATIENTS

Cardiovascular System:	
Arteriosclerotic cardiovascular disease	7
Myocardial infarction	2
Cor Pulmonale	1
Secondary Anemia	1
Toxic myocarditis	1
Hypertension, essential	3
Raynaud's Phenomenon	1
Arteriosclerosis	5
Coronary Artery Heart Disease	3
Hypertensive cardiovascular disease	2
Coronary Atherosclerosis	2
Polycythemia Rubra Vera	1
Varicose Veins	1
Bundle Branch Block	1
Complete Heart Block	1
Congestive Failure	2
Peripheral Atherosclerosis	1
Cardiomegaly	1
Atherosclerosis obliterans	1
Cerebral Atherosclerosis	1
Coronary Thrombosis	1
Ventricular hypertrophy	1
Gastrointestinal System:	
Cholelithiasis	2
Chronic passive congestion of liver and spleen	1
Gastritis, Alcoholic	1
Haemorrhoids	1
Ulcer, peptic	4
Genitourinary System:	
Benign prostatic hypertrophy	2
Bladder Calculus	1
Carcinoma of kidney with metastasis	1
Urethral stricture	1
Urethro-peritoneal fistula	1
Chronic cystitis	2
Chronic pyelonephritis	2
Vaginitis	1
Nephrosclerosis	1
Bacilluria	1
Uremia	1
Urinary tract infection	1
Hormonal System:	
Diabetes Mellitus	4

TABLE 16 -- REPORT OF OPERATING ROOM DEPARTMENT PROCEDURES

BY OUR CONSULTANTS:	Major Surgery	Minor Surgery	Other Exams
E.E.N.T. PROCEDURES - Dr. W. MacIsaac			
Bronchoscopics		13	
E.E.N.T. Exams, consultations, etc.			14
UROLOGICAL PROCEDURES - Dr. D.B. Archibald			
Cystoscopic Exams		23	
Urethral Dilatation		10	
Crushing Bladder Calculus		1	
Other Examinations and consultations			16
GYNECOLOGY			1
		47	31
BY OUR FULL-TIME MEDICAL STAFF			
Biopsy, Scalene Node		2	
Aspirations, chest		9	
Aspirations, other		14	
Lumbar Puncture		79	
Repair of Lacerations, etc		10	
Plaster casts		3	
Sigmoidoscopic and Proctoscopic			5
E.E.N.T.			23
Caloric Testing			2
P.V.			8
		117	38
NURSING PROCEDURES (by O.R. Staff)			
Dressings, etc.			83
Ear Syringe, etc.			22
Injections			71
Postural Drainage			9
B.C.G.			7
ANAESTHESIA			
Inhalation			0
Intravenous			3
Local			129
Topical			33

TABLE 17 -- REPORT OF CLINIC SERVICES:

OUT-PATIENT CHEST CLINICS		Patients	Visits	X-Rays
D.V.A.	- Patients	108		
	- Visits		133	
OTHER	- Patients	156		
	- Visits		326	
		264	459	475
STAFF CLINICS	- Patients	46		
	- Visits		192	452
		310	651	927

TABLE 18 -- LABORATORY REPORT: UNITS OF WORK PERFORMED

	Total Exams	Unit Value	In-Patient Units	Out-Patient Units	Total Units
HAEMATOLOGY:					
Bleeding Time	2	1	1	1	2
Coagulation Time	2	2	2	2	4
Differential	967	2	1206	728	1934
Haematocrit	971	1	608	363	971
Haemoglobin	985	1	615	370	985
Platelet Count	9	3	24	3	27
Prothrombin Time	2	2	2	2	4
Red Cell Count	13	1	12	1	13
Sedimentation Rate	952	1	594	358	952
White Cell Count	976	1	616	360	976
			3680	2188	5868
URINALYSIS:					
Routine	640	2	1256	24	1280
Single constituents	3	1	2	1	3
			1258	25	1283
BIOCHEMISTRY:					
Bilirubin, direct & total	5	4	8	12	20
Glucose	479	2	930	28	958
Glucose Tolerance	2	10	20	-	20
Icterus Index	137	1	120	17	137
Non-Protein Nitrogen	232	4	912	16	928
Blood Urea Nitrogen	221	4	864	20	884
Alkaline Phosphatase	359	6	1794	360	2154
Protein, A/G ratio	3	6	18	-	18
SGOT	116	5	470	110	580
SGPT	112	5	460	100	560
Cholesterol	1	5	-	5	5
Occult Blood	16	1	16	-	16
			5612	668	6280
TB BACTERIOLOGY:					
T.B. sputum smears	125	3	375	-	375
other smears	2	4	8	-	8
T.B. concentrations	489	4	1956	-	1956
			2339	-	2339
CEREBROSPINAL FLUID:					
Cell count	82	1	82	-	82
Chloride	82	3	246	-	246
Protein	82	2	164	-	164
Sugar	82	2	164	-	164
			656	-	656
Blood Bank			2		2
Procurement and Handling of specimens			1477	528	2005
TOTAL UNITS OF WORK PERFORMED			15024	3409	18433

TABLE 19 — LABORATORY REPORT: WORK REFERRED OUT TO OTHER LABORATORIES

	Total Exams	Unit Value	In-Patient Units	Out-Patient Units	Total Units
HAEMATOLOGY:					
Blood film	1	2	2	-	2
Bone Marrow	3	7	21	-	21
Differential	1	2	2	-	2
Platelet Count	2	3	6	-	6
Haematocrit	1	1	1	-	1
Haemoglobin	1	1	1	-	1
White Cell count	1	1	1	-	1
			34	12	46
BIOCHEMISTRY:					
Urine - Pregnancy test	2	2	4	-	4
17-Ketosteroids	2	12	24	-	24
17-Corticoids	2	15	30	-	30
Calcium	50	4	200	-	200
Chloride	50	3	150	-	150
CO2 - Astrup	8	5	40	-	40
Cholesterol	1	5	5	-	5
Creatinine	4	3	12	-	12
Phosphorus	50	4	200	-	200
Potassium	50	3	150	-	150
Thyroxine	8	4	16	16	32
Sodium	50	3	150	-	150
Uric Acid	4	3	12	-	12
Serum Iron	3	4	12	-	12
			1005	16	1021
BACTERIOLOGY:					
T.B. Cultures & sens.	2684	6	16104		16104
Other cultures, sputum	138	6	828		828
urine	156	6	936		936
Miscellaneous	43	6	252	6	252
sensitivities	117	4	468		468
O.R. Sterility control	11	3		33	33
Other				177	177
			18594	216	18810
HISTOPATHOLOGY	4	8	32		32
CYTOPATHOLOGY	126	5	630		630
BLOOD BANK			16		16
SEROLOGY					
VDRL	138	1	138	-	
Wassermann	6	2	12		
Paul Bunnell	1	3	3		
R.A. Latex Fixation	1	3	3		
Widal	1	6	6		162
CEREBROSPINAL FLUID	4	2	8		8
TOTAL UNITS OF WORK REFERRED OUT			20481	244	20725

TABLE 20 -- AUTOPSY STATISTICS

Hospital Deaths	5
Deaths due to Tb	-
Autopsies	3
Autopsy Rate	60%

TABLE 21 -- REPORT OF X-RAY DEPARTMENT

	In-Patient Exams	Out-Patient Exams	Staff Exams	Total Exams	T.M. Units	R.M. Units
Chest, single	289	432	438	1159	2318	2318
" multiple	143	25	2	170	510	340
" planigraph	49	5	1	55	275	275
Bronchogram, unilateral	4	-	-	4	16	16
" bilateral	4	-	-	4	20	24
Abdomen	7	1	-	8	16	16
Gall Bladder	1	-	-	1	4	3
Pyelogram, intravenous	4	-	-	4	24	12
" retrograde	26	-	-	26	104	52
Bones and joints:						
Ribs and shoulders	2	1	1	4	12	8
Skull, etc	-	-	-	-	-	-
Hips and pelvis	11	-	-	11	22	22
Spinal column	17	6	1	24	96	72
Extremities	11	5	9	25	50	50
	568	475	452	1495	3467	3208
Electrocardiograms	63	2	1	66		
Pulmonary Function	16	-	-	16		

The above films were interpreted by our own medical staff. A few problem cases were referred to other radiologists (Dr. J.R. Corbett) in consultation, and problem chest films were referred to the N.S. Sanatorium in consultation. Patients requiring G.I.Series and other specialist examinations were referred to the Out-Patient department of St. Rita Hospital or other hospitals.

Electrocardiograms were referred to Dr. H.M. Holden for interpretation.

Most patients admitted to Point Edward Hospital or to the Out-Patient Chest Clinics had had previous chest x-rays elsewhere. Whenever possible these were obtained and compared with our own more recent films. No exact count was kept, but the figure would be in excess of 500 films or 1000 R.M. units.